Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TERRY BEAL, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TEXAS 77027

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-3892-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "paid maximum 3 musculoskeletal body areas per rule 134.201"

Response Submitted by: Liberty Mutual, 2875 Browns Bride Road, Gainesville, GA 30501

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2011	99456-W5-WP	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation(s) of benefits dated May 26, 2011
   42 - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE

   Explanation(s) of benefits dated June 23, 2011
   - X598 – CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED; NO ADDITIONAL PAYMENT DUE.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

The provider billed the amount of $1250.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Impairment ratings were performed with a combination of Diagnosis Related Estimates (DRE) as well as Range of Motion (ROM) methods. Compensable body areas were rated and additional non-compensable body areas were rated for an alternative report. The requestor billed an additional line item CPT code 99456-MI for $50.00 which was paid and is not in dispute. The documented body areas which count toward reimbursement must be reviewed. Review of the compensable body areas rated shows three musculoskeletal areas (spinal with DRE-cervical and lumbar), (lower extremity with ROM-left knee and left/right ankles), (upper extremity with ROM-right shoulder. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar and cervical are one part of one area, the spine. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using DRE Category I method on the lumbar and cervical (spinal region) is $150.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on the left knee and ankles (lower extremities) is $300.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(b), the MAR for a 2nd musculoskeletal area IR using Range of Motion (ROM) on the right shoulder (upper extremity) is $150.00. The listing of non-compensable areas rated shows a right elbow ROM does not add any further reimbursement as it is part of upper extremity ROM reimbursement. The dispute is over two additional body areas to non-musculoskeletal areas. A closed head injury (compensable) is noted as resolved with a rating of 0%. A facial contusion (non-compensable) is also noted as resolved with a rating of 0%. This type of IR is done to areas defined according to 28 Texas Administrative Code §134.204 which states in part (j)(4)(D)(i)(I-III) & (ii):

> (D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.
> (i) Non-musculoskeletal body areas are defined as follows:
> (I) body systems;
> (II) body structures (including skin); and,
> (III) mental and behavioral disorders.
> (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

The calculation of non musculoskeletal IR are based on 28 Texas Administrative Code §134.204 which states in part (j)(4)(D)(iv)(I-III):

> (iv) When there is no test to determine an IR for a non-musculoskeletal condition:
> (I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.
> (II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.
> (III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

The reimbursement for each of these areas is described in 28 Texas Administrative Code §134.204 in part (j)(4)(D)(v) which states:

> (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

The requestor stated in their MMI/IR report that the AMA Guides were used to show how the IR rating was achieved for the non-musculoskeletal body conditions of closed head injury and facial contusion injury. The respondent has reimbursed the amount of $950.00. Therefore, 28 Texas Administrative Code §134.204 (j)(4)(D)(v) allows $300.00 in additional reimbursement due for these ratings.

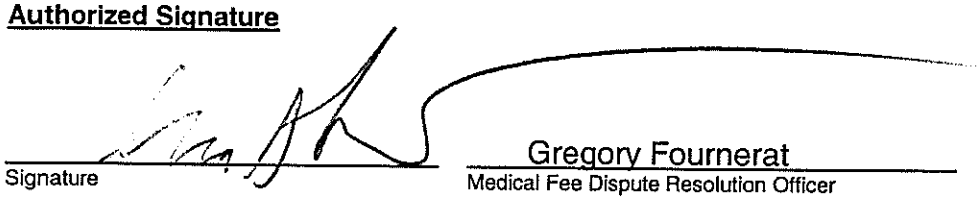
Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature



Signature

Gregory Fournerat
Medical Fee Dispute Resolution Officer

November 18, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.